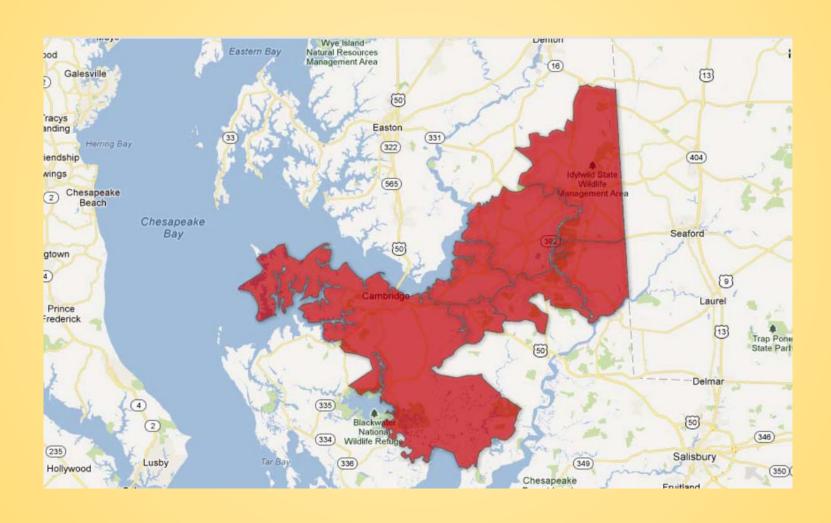


#### **Program Objectives**

- 1. Improve outcomes and reduce risk factors related to diabetes, hypertension, asthma, and behavioral health issues
- 2. Expand the primary care workforce
- 3. Increase the community health workforce
- 4. Increase community resources for health
- 5. Reduce preventable emergency department visits and hospitalizations
- 6. Reduce unnecessary costs in healthcare

## **Target Population**



### HEZ Strategic Domains to Support Successful Chronic Disease Management

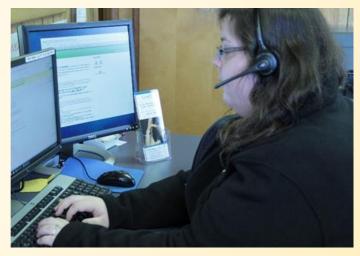
- Provider Accessibility and Capacity incentives for provider recruitment/retention, new and expanded healthcare delivery sites, co-located and integrated services
- Community Supports for Self-Management new and expanded community resources and self-management supports, team-based approach, addressing social determinants of health
- Quality Care health literacy, patient activation, cultural/linguistic competency efforts for effective communication between patient and provider

#### **Provider Accessibility and Capacity**

- Recruited satellite OBGYN office plus six physicians through hiring incentives
- Expanded access to pediatric care, including somatic and mental health, in school settings
- Opened adult outpatient mental health clinic
- Established dispatch/response team to help people in crisis with behavioral health issues
- Provided income tax credits to providers practicing in Zone and accepting uninsured and Medicaid patients; advocated for preceptor tax credit bill







#### **Community Supports for Self-Management**

- Obesity treatment program accessible to low income patients
- Implemented school-based asthma management program
- Federally Qualified Health Center (FQHC) hired Care Coordinator and Community Support Specialists to ensure patients referred appropriately and assist with navigating healthcare system
- Established and integrated Community Health Worker Team to solidify reach into homes and communities through various services (including telehealth component)







### Community Supports for Self Management

- Co-located mental health and substance abuse peer recovery support specialists at drop-in center
- Peer Recovery Support Specialists also visited hospital and mental health clinic to connect with patients





#### **DRI-DOCK Recovery & Wellness Center**

Partnered with Dorchester County Addictions Program 524 Race St., Cambridge, MD 410-228-7714

Open: Mon & Tues 8am-7pm Wed, Thurs & Fri 8am-6pm Tuesday Monday Wednesday Thursday Saturday Friday 2 Emotions 3 Safe in The Spirituality in City 2:00pm Life Skills Group Anonymous w/CVI Recovery 1:30pm Peer Support, NARCAN TRAINING 1:30pm All Recovery 5pm 10-12PM & 1-3PM Conversation (₩) 5:30pm Y12SR: The Yoga of KEEP € 5:30PM Support Group 5pm 1:30pm 12-step recovery CALM Group 3pm-4pm 3:30-5:00pm 10 Safe in The 12 13 CARRY CLOSED FOR City 2:00pm Life Skills Group Spirituality in Peer Support, NALOXONE 1:30pm Recovery 1:30pm Coffee & COLUMBUS 10-12PM & 1-3PM All Recovery 5pm Conversation 5:30PM Ex-Offender Support 1:30pm Group 5pm 21 16<sub>Emotions</sub> 17 Safe In The 18 Life Skills 19 Spirituality in City 2:00pm Group 1:30pm Anonymous w/CVI Recovery 1:30pm Peer Support, Y125R:The Yoga of NARCAN TRAINING All Recovery 5pm Coffee & 10-12PM & 1-3PM 12-step recovery Ex-Offender (NF) 5:30pm Conversation 3:30-5:30pm 5:30pm Support Group 5pm FAMILY NIGHT Group 3pm-4pm 23 Emotions 24Safe In The Anonymous w/CVI City 2:00pm Life Skills Group Spirituality in Peer Support, 80's Recovery 1:30pm 1:30pm Coffee & 10-12PM & 1-3PM Throwback (NF) 5:30pm Ex-Offender Conversation Support Group 1:30pm (##) 5:30pm Halloween Group 3pm-4pm All Recovery 5pm Costume Party!!! 31 Safe In The 30 Emotions

7pm-10pm



The staff at Dri-Dock are Certified Peer Recovery Specialists, which means they have lived experience in recovery. We are here to provide support during your journey in recovery & wellness! Contact us for the support you need! \*410-228-3230\* All Are Welcome!





City 2:00pm

10-12PM & 1-3PM

5:30pm

#### **Quality Care**

- FQHC has EHR-based needs and health literacy assessment, works with patient to develop patient-centered treatment plan, and mandates annual cultural competency training
- Developed CHW workforce by providing core training and ongoing updates
- CHW team implemented CLAS standards and promoted patient empowerment
- Use of certified medical interpreters, language line, and Braille services
- Ongoing staff training, such as SAMHSA trauma-informed care training
- Workforce development efforts through use of incentives providers required to obtain at least 6 CME credits of cultural and linguistic competency training







#### Key Organizational Activities and Strategies

- Collaborative effort among different types of organizations
- Shared values and goals
- Coordination to address complex health determinants
- Coalition made up of 23 committed leaders, community members, advisory partners, etc. with different skill sets and resources meets monthly to strategize



FUNDED PARTNERS	SERVICES PROVIDED		
Associated Black Charities (ABC)	Community health workers, integrate w/ healthcare system		
Caroline County Health Department (CCHD)	School based mental health services, adult outpatient mental health therapy		
Chesapeake Voyagers, Inc. (CVI)	Mental health peer recovery support services		
Choptank Community Health System (CCHS)	Care coordination, wrap-around services		
Dorchester County School Based Wellness Center (DSBW)	Somatic and behavioral health care, including asthma management		
DRI-Dock (DD)	Substance use peer recovery support services, drop-in center		
Eastern Shore Area Health Education Center (ESAHEC)	Working to establish CHW training institute, provide training, advocacy for preceptor bill, miniresidencies		
Maryland Healthy Weighs (MHW)	Weight loss (Phase I) and weight management (Phase II) obesity treatment program		
Maryland State Medical Society (MedChi)	Provider recruitment, HEZ marketing		
Affiliated Sante Group Eastern Shore Crisis Response (receives funding through BHA)	Crisis response, resource help		

# **Participant Outcomes**

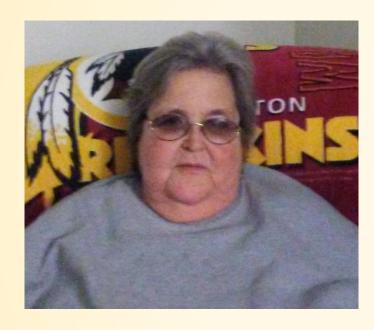
HEZ Metrics	Year 1	Year 2	Year 3	Year 4	Total
Total Number of Unduplicated Patients	591	1,253	1,550	2,704	6,098
Total Number of Patient Visits	2,687	7,899	9,240	7,261	27,087

#### Successes

- 84% of CHW participants advocated for their health needs during primary care visits
- Through telehealth partnership, increased PCP follow-up among participants by 7%
- 87.3% of CHW participants with hypertension showed an improvement in baseline BP
- FQHC and hospital system established ED Diversion Collaborative
- 121 patients completed >8 weeks of phase 1 obesity treatment, resulting in 13% average BMI reduction estimated \$11,000 savings in annual medical care costs for each patient
- Mobile Crisis Team's median response time averaged 19 minutes (exceeding goal of <60 min)</li>
- Total of 887 behavioral health dispatches diverted from hospitalization or incarceration
- Residual benefits continuing to address chronic disease burden through established partnerships for other initiatives, enhanced community-clinical linkages, and leveraging of resources

#### **Participant Testimonials**

#### ABC CHW Team - Melody



"She's my angel. Several times I've thought about suicide because I'm tired of being sick. Without Ms. Joyce, I don't know what I would have done. She's helped me in so many ways...moral support, gone to the doctor with me, taken me to the grocery store because I don't have anybody."

#### DSBW Asthma Management Program - "D"

- 8<sup>th</sup> grader
- Multiple asthma attacks, sometimes in same week
- Missing school and not doing well
- Initial Peak Flow measurements <100 (Red Zone)
- After much teaching, new medication, peak flows closer to 200

### Challenges

- Data capabilities significant challenges with data collection, HIPAA, CRISP access
- ROI is not always tangible, and too soon to effectively demonstrate
- Need to continue advocating for and educating about effectiveness of CHWs
- Staff turnover and provider recruitment
- Sustainability funding for continued support

All of this takes time and is not easily resolved!

#### Sustainability Update

- CHW training, peer recovery services, crisis response services continue with grant funding
- Care coordination expanded to all FQHC sites through quality grant funding, agreement with Priority Partners, John Hopkins study
- Down to two CHWs only serving Dorchester County, but obtained 501(c)3 status as Eastern Shore Wellness Solutions, Inc.
- Decreased coverage at Dorchester school-based wellness center and no longer offering Asthma Management Program – clinicians split between multiple schools don't have time to do more intensive monitoring and follow-up
- Obesity treatment program transitioned to non-medical model and no longer provides reduced costs of meal replacements for low income participants because third party payers would not sustain funding through insurance payments
- Adult outpatient and some school-based mental health services transitioned to private entity because fee-for-service did not bring in enough revenue to sustain



Angela Mercier, Health Education Program Manager
Dorchester County Health Department
3 Cedar Street
Cambridge, MD 21613
Phone: 410-901-8126

Email: angela.mercier@maryland.gov